Care Management Workflow

Initial Contact: (Billing information listed is in reference to BCBSM, BCN/BCNA- Please review MICMT billing guidelines https://micmt-cares.org/g9001-comprehensive-assessment for other payer information)

- Initial Contact can happen one of the following ways:

    - Practice identifies possible care management patients through chart prep, patient registries, health focus, patient phone calls etc.

    - Providers and Care Manger are notified of potential care management patients who are on the schedule each day. (Cold Calling can also happen from the patient identifiers listed above)

        1. Care Manager enters room to discuss Care Management services with patient before the provider enters the room. *Bonus- this helps with perception of patient wait times in room* If provider enters while Care Manager present- warm handoff to provider happens.

            - **What can be billed G9002** if patient accepts OR **G9002 P2 modifier** if patient declines (Once per year per condition)

            - If warm handoff did not happen by provider entering the room, the Care Manager follows up with the provider at some point to let them know what was discussed with patient and that they accepted Care Management (team conference)

                - **What can be billed G9007** can be billed. *Hint if this team conference happens 24-48 hours later, this code would be submitted on a different DOS and help assist in getting two touches*

        2. The provider meets with the patient and briefly discusses Care Management services and then does a warm handoff with the patient.
            - **What can be billed? G9008** by provider for discussing services with patient. If patient declines, **G9008 P2 modifier.**

            - If a warm handoff cannot happen, the provider lets the patient know the Care Manager will be contacting them and hands the

patient the offices Care Manager flyer which contains a picture of the Care Manager and information of Care Manager services.

- The Care Manager flyer could also be handed to the patient from the front office staff when patient checks in if the front office staff is also aware of patients who are candidates on the schedule. OR have front office staff hand to all patients and let them to know to talk to their provider if they are interested in services.

3. Care Manager calls patients to offer Care Manager services.
    - **What can be billed?**
        - **98966-98968** depending on the length of conversation.
        - **G9002** if it is documented why the visit was conducted telephonically rather than virtually (i.e., no smart phone or can't get video to work)
        - **G9002 2P modifier** If patient declines services (once per condition per year)

- Introduction/Explanation of Care Management (Can be used for any of the scenarios above)
    - Hello {Patient name}, your provider wanted me to reach out to you about Care Management. I believe your provider discussed this with you during your most recent visit. Were you offered our Care Management flyer? Would be ok if I verbally told you about our Care Management Program and then we can see if you have any questions for me?
    - {Practice Name}'s care management program is designed to help you get and/or stay healthy!
    - In most cases, it is covered by your insurance without cost to you.
    - What is your biggest health concern today?
        - What do you know about your condition?
    - Assessment/Surveys
    - Health history
    - Treatment Goals- If a patient is struggling to make goals during the initial visit, ask them to think about something they would like to change for the next visit. The change can be big or small.
        - These questions can be extremely helpful once the patient has defined a change they would like to make; perhaps the care manager has to help the patient come to the change they want to make through MI:
            1. What part of your wants to make this change?

2. What are the three best reasons for you to do it?
3. How might you go about it, in order to succeed?
4. On a scale from 0 to 10, how important would you say that it is for you to make this change? (And why are you at _ and not zero?)

Try to do two reflections to each question listening for change talk and offer a summary at the end

1. **Billing Tip:** After each encounter with the patient, provide a short face-to-face summary to the patient's provider. This could be done while passing each other in the hallway OR if the provider agrees, a scheduled Care Management review can occur weekly, monthly, or however often the practice/provider prefers. G9007 can be billed for each patient reviewed between the Care Manger and provider.

2. **Billing Tip:** Pick an age range to discuss advance care planning; Make it a habit to bring up ACP with all patients 65 and older (or you can start younger). This conversation may be as simple as, "Do you have an advanced directive on file? **OR** "I noticed we don't have an advanced directive on file?" **OR** I noticed we have your Advanced Directive on file would you like to review it to ensure it is up to date? Depending on what the patient says, ask if they would like to discuss or simply offer some sort of advanced directive resource such as an ACP Decisions Handout/Video and ask if it would be ok to discuss at a future touch point or instruct the patient to call with any questions. This will allow S0257 to be billed in combination with any other Care Management codes such as an G9002; This can also be billed for a patient who declines Care Management. Two codes on the same Date of Service (DOS) will not count towards two touches BUT once the initial 1% target is met, this code will help with the 4% population management goal!